WORKERS' COMPENSATION FIRST CHECK PROCESS

_____ **Process Level**

_____ **Workers' Comp Claim Number From T.P.A.**

_____ Last Name

_____ First Name

___ MI

_____ Employee Number

INJURY INFORMATION

_____ **Date of Injury**

_____ **Last Day Worked**

_____ **Return to Work Date**

_____ **Partial Return to Work Date**

TYPE OF CLAIM

Non Assault Employee _____

Rate of Pay $ _____

Public Act (Assault) Employee _____

Rate of Pay at Time of Injury $ _____

True Marital Status: Married ____ **Single** ____

True Number of Exemptions: ____

PAYMENT

$ _____ **Initial Benefit Check Amt.**

_____ **Time Period 1st Check Covers**

$ _____ **Workers' Comp. Wkly Amt.**

Bi-Weekly Standard Hours _____

Shift 2 _____
Shift 3 _____

Special Pay Premium Code _____

Will leave time be used? _____ **Y/N**

Type of Leave
(List in the order to be used)

1. _____
2. _____
3. _____

Additional Information _____

_____

_____

*****Attach copy of DCDS time records with corrections for the time period specified above.**
*****Fax the completed form to 517-373-6458**

CONTACT

Contact Person _____

Phone Number _____ **Fax** _____ **Email** _____